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Section

508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) MassHealth Standard members described in 130 CMR 505.002(B), (C), (D), (E), and (F), as well as certain MassHealth Family Assistance members described in 130 CMR 505.005(E), and Basic members described in 130 CMR 505.006(B), must enroll in one of the following managed care options unless excluded from participation in 130 CMR 508.004:

(a) Primary Care Clinician (PCC) Plan; or

(b) MassHealth-contracted managed care organization (MCO).

(2) MassHealth Family Assistance members described in 130 CMR 505.005(F) and MassHealth Standard members described at 130 CMR 505.002(H) must enroll in the PCC Plan, unless excluded from participation in 130 CMR 508.004.

(3) MassHealth Essential members who have coverage through the purchase of medical benefits described in 130 CMR 505.007(B) and (E) must enroll in the PCC Plan.

(B) Obtaining Services.

(1) Primary Care. When the member selects or is assigned to either a PCC or MCO, that MassHealth managed care provider will deliver the member's primary care, decide if the member needs medical care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services (Excluding Behavioral Health Services).

(a) Service Delivery to Members Enrolled in the PCC Plan. All medical services to members enrolled in the PCC Plan, except those services listed in 130 CMR 450.118(J), require a referral or authorization from the PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(b) Service Delivery to Members Enrolled in an MCO. All medical services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the referral requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and referral requirements.

(3) Behavioral Health Services.

(a) Members Enrolled in the PCC Plan. All members who enroll in the PCC Plan receive behavioral health (mental health and substance abuse) services through MassHealth's behavioral health contractor. See 130 CMR 508.003.

(b) Members Enrolled in an MCO.

(i) Members who enroll in a MassHealth-contracted MCO that is under contract to provide behavioral health services receive behavioral health services through that MCO.

(ii) All behavioral health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and authorization requirements.

(c) Members with Presumptive or Time-Limited Eligibility, or Fee-for-Service. Members with presumptive or time-limited eligibility, or fee-for-service receive behavioral health services through any qualified participating MassHealth provider.

508.002: Choosing a MassHealth Managed Care Provider

All MassHealth members, except those excluded under 130 CMR 508.004, must enroll with a MassHealth managed care provider. For MassHealth Basic members, described at 130 CMR 505.006(B), and MassHealth Essential members, described at 130 CMR 505.007(B) and (E), services are available only as of the member's enrollment effective date, as established by MassHealth in accordance with 130 CMR 508.002(I), with a MassHealth managed care provider. MassHealth Essential members described in 130 CMR 505.007(E) are also provided services under MassHealth Limited pursuant to 130 CMR 505.007(E) and 505.008.

(A) Selection of a Managed Care Provider.

(1) Procedure. MassHealth notifies the member of the availability of MassHealth managed care providers in the member's service area, and of the member's obligation to select such a provider within the time period specified by MassHealth. The member may select any provider from MassHealth's list of MassHealth managed care providers in his or her service area, if the provider is able to accept new patients.

(2) Member's Service Area. The member's service area is determined by MassHealth based on zip codes. Service area listings may be obtained from MassHealth.

(B) Assignment to a Managed Care Provider. If a member does not choose a managed care provider within the time period specified by MassHealth in a notice to the member, MassHealth assigns the member to a MassHealth managed care provider.

(C) Criteria for Assigning Members.

(1) MassHealth assigns a member eligible to enroll with a managed care provider only if the provider is:

(a) in the member's service area as described in 130 CMR 508.002(A)(2);

(b) physically accessible to the member, if the member is disabled;

(c) suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician);

(d) able to communicate with the member directly or through an interpreter, unless there is no medical care available in the member's service area that meets this requirement; and

(e) located in an area to which the member has available transportation.

(2) (a) For MassHealth Standard members only, if the Division determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) is available in the member's service area, the member may:

(i) choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or

(ii) select an available MassHealth managed care provider outside of the member's service area.

(b) Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(i) must obtain any behavioral health services through the Division's behavioral health contractor. All other services for which the member is eligible may be obtained through any qualified participating MassHealth provider.

(3) If, after a determination by the Division under 130 CMR 508.002(C)(2)(a), the Division determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) has become available, the member must enroll with such a provider, unless the member is otherwise enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(ii).

(D) Notification. The Division will notify a member in writing of the name and address of the member's MassHealth managed care provider, and the member's enrollment effective date with the provider.

(E) Transfer. The member may transfer to or from an available MassHealth managed care provider at any time.

(F) Out-of-Area Managed Care Provider. A member who seeks to enroll with a MassHealth managed care provider outside of the member's service area must submit a request in writing to the Division on forms provided by the Division. The Division will grant a request for an available out-of-area MassHealth managed care provider where the Division determines that:

(1) there is no MassHealth managed care provider available in the member's service area that is able to communicate with the member directly or through an interpreter;

(2) the travel time or distance to the requested out-of-area MassHealth managed care provider is equal to or less than the travel time to a MassHealth managed care provider in the member's service area, or the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by MassHealth, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(G) Disenrollment or Transfer of Members. MassHealth may disenroll or transfer a member from a MassHealth managed care provider if the provider demonstrates to MassHealth's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, MassHealth states the good cause basis for disenrollment or transfer in a notice to the member.

(H) Reenrollment. Any member who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled.

(I) Enrollment of MassHealth Basic and MassHealth Essential Members.

(1) After MassHealth sends members a notice of eligibility for the purchase of medical benefits, MassHealth enrolls them with a MassHealth managed care provider. MassHealth Basic members, described at 130 CMR 505.006(B), must enroll in a Primary Care Clinician Plan or with a MassHealth-contracted managed-care organization. MassHealth Essential members, described at 130 CMR 505.007(B) and (E), must enroll in the Primary Care Clinician Plan. Enrollment is accomplished in one of the following ways and within the following time frames.

(a) After MassHealth approves eligibility for the purchase of medical benefits, the member may contact MassHealth directly by telephone at the number indicated on the eligibility notice, or in person, and provide all information needed to enroll the member with a MassHealth managed care provider. If complete information is provided, MassHealth enrolls the member, in accordance with the member's selection, effective no later than 10 business days after MassHealth receives this information.

(b) After MassHealth approves eligibility for the purchase of medical benefits, MassHealth sends the member enrollment materials and a managed care provider selection form. If the member completes and returns this form to MassHealth within the time frame specified by MassHealth, and if the information provided is complete, MassHealth enrolls the member, in accordance with the member's selection, effective no later than 10 business days after MassHealth receives the completed enrollment form. MassHealth considers only such forms that the member sends to MassHealth after MassHealth has approved the member's eligibility.

(c) If the member fails to notify MassHealth of his or her enrollment selection, either by telephone, in person, or by submitting a completed enrollment form within the time frame specified by MassHealth, MassHealth selects a MassHealth managed care provider for the member. MassHealth enrolls the member effective no later than 35 days after the date MassHealth determined the member to be eligible for the purchase of medical benefits. The member is notified in writing of the enrollment selection and the effective date of enrollment.

(d) If MassHealth determines a member to be eligible for the purchase of medical benefits under MassHealth Basic or MassHealth Essential, and if that member was enrolled with a MassHealth managed care provider during an earlier period of MassHealth eligibility, MassHealth may automatically enroll that member with the same provider pursuant to 130 CMR 508.002(H).

(2) If, at any time after MassHealth enrolls the member with a MassHealth managed care provider, the member wants to transfer to or from an available managed care provider, the member may notify MassHealth, and the effective date of medical coverage with the newly selected provider will be effective no later than 10 business days after MassHealth receives notification of the requested change.

(3) The time frames for establishing an effective date of enrollment may be extended if:

(a) the member asks MassHealth to delay any action described in 130 CMR 508.002(I) or otherwise causes a delay;

(b) MassHealth needs additional time to resolve conflicting information; or

(c) MassHealth does not have sufficient information to enroll or reenroll the member.

(4) In no event will a MassHealth Basic or MassHealth Essential member who is eligible for the purchase of medical benefits be enrolled with a MassHealth managed care provider with an effective date that is before the date of MassHealth's issuance of a notice to the member stating that the member is eligible for MassHealth Basic or MassHealth Essential.

508.003: Behavioral Health Contractor

The following applies to MassHealth members who receive behavioral health services through MassHealth's behavioral health contractor. See 130 CMR 508.001(C).

(A) Nonemergency Behavioral Health Services. All behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with MassHealth's behavioral health contractor. MassHealth's behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

(B) Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with MassHealth's behavioral health contractor.

508.004: Members Excluded from Participation in Managed Care

The following members are excluded from required participation in MassHealth's managed care options, and receive those MassHealth services for which they are eligible from any qualified participating MassHealth provider of those services:

(A) a MassHealth Standard or CommonHealth member who has other health insurance, including Medicare;

(B) a MassHealth Family Assistance, Basic, or Essential member who has or has access to other health insurance;

(C) a member who is aged 65 or older, except for MassHealth Standard members who may voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008;

(D) a MassHealth Standard member institutionalized in:

(1) a nursing facility;

(2) a chronic disease or rehabilitation hospital;

(3) a state school for the mentally retarded; or

(4) a state psychiatric hospital;

(E) a member who is eligible solely for:

(1) MassHealth Limited; or

(2) MassHealth Prenatal;

(F) a MassHealth Standard or CommonHealth member who is receiving hospice care through MassHealth, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less;

(G) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106; and

(H) a MassHealth Standard, Family Assistance, or CommonHealth member who has presumptive or time-limited eligibility is excluded from enrolling in the PCC Plan or an MCO for primary care.

508.005: MassHealth Managed Care Providers

(A) Primary Care Clinicians Participating in the PCC Plan. The list of primary care clinicians that the Division will make available to members may include any one of the following who is approved as a PCC by the Division and who practices within the member's service area:

(1) a physician in one of the following fields of medicine:

(a) internal medicine;

(b) family or general practice;

(c) pediatrics;

(d) obstetrics;

(e) gynecology;

(f) obstetrics/gynecology; or

(g) physiatry;

(2) a physician specialist who is board-certified or eligible for board certification in internal medicine or pediatrics and who agrees to provide primary care in accordance with Division requirements;

(3) an independent nurse practitioner;

(4) a licensed community health center with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1);

(5) an acute hospital outpatient department with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1); or

(6) a group practice with one or more practicing physicians or independent nurse practitioners who meet the requirements of 130 CMR 508.005(A)(1).

(B) Managed Care Organizations. The list of MCOs that the Division will make available to members will include those MCOs that contract with the Division and provide services within the member's service area.

(C) Senior Care Organizations. The list of senior care organizations that the Division will make available to members will include those senior care organizations that contract with the Division and provide services within the member's service area.

508.006: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000 et seq. to appeal:

(A) the Division's determination that the MassHealth Standard member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001(A);

(B) a determination by the Division's behavioral health contractor, under 130 CMR 508.003(A), by one of the Division's managed care organization (MCO) contractors, under 130 CMR 508.001(B)(2)(b), or by a senior care organization under 130 CMR 508.008(C), to deny, reduce, modify, or terminate a covered service, if the member has exhausted all remedies available through the contractor's internal appeals process;

(C) the Division's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.002(F); or

(D) the Division's disenrollment or transfer of a member from a MassHealth managed care provider under 130 CMR 508.002(G).

(130 CMR 508.007 Reserved)

508.008: Voluntary Enrollment in Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

(1) be aged 65 or older;

(2) live in a designated service area of a senior care organization;

(3) not be diagnosed as having end-stage renal disease;

(4) not be subject to a six-month deductible period under 130 CMR 520.028;

(5) not be a resident of an intermediate care facility for the mentally retarded (ICF/MR); and

(6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection of a Senior Care Organization. The Division will notify members of the availability of a senior care organization in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any senior care organization in the member's service area. A service area is the specific geographical area of Massachusetts in which a senior care organization agrees to serve its contract with the Division and the Centers for Medicare and Medicaid Services. Service area listings may be obtained from the Division or its designee.

(C) Obtaining Services. When a member chooses to enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008, the senior care organization will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each senior care organization is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a senior care organization at any time by submitting a notice of disenrollment to the Division or its designee. Disenrollment notices received by the Division or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The Division may discharge or transfer a member from a senior care organization where the senior care organization demonstrates to the Division's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the Division will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization under 130 CMR 508.008, a member may not concurrently participate in any of the following programs:

(1) the Home and Community-Based Services Waiver described in 130 CMR 519.007(B);

(2) the Section 1915 Home and Community-Based Services Waiver for the Mentally Retarded administered by the Department of Mental Retardation;

(3) the Program of All-Inclusive Care for the Elderly (PACE) described in 130 CMR 519.007(C); and

(4) any Medicare+Choice plan or Medicare demonstration program.

(130 CMR 508.009 through 508.015 Reserved)

508.016: Copayments Required by MassHealth

MassHealth requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 520.036 through 520.040. If the usual and customary fee for the service is less than the copayment amount, the member must pay the amount of the service. Members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must:

(1) be approved by MassHealth:

(2) exclude the persons and services listed in 130 CMR 520.037;

(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 520.038; and

(4) include the calendar-year maximum set forth in 130 CMR 520.040. (See also 130 CMR 450.130.)